Appendix 3

GOOD OR BAD NEWS? MEDIA COVERAGE OF SOLDIERS: FOCUS ON BEHAVIORAL HEALTH IN IRAQ DURING OPERATION IRAQI FREEDOM 05-07

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INTRODUCTION

The mental health of soldiers during the wars in Iraq and Afghanistan has generated ongoing media interest, focusing on major issues such as suicide, administrative discharges, psychiatric medications, fitness to deploy, care of wounded soldiers, and traumatic brain injury. This appendix provides some basic guidance for interacting with the media, followed by a discussion of media coverage during a specific period of time. Questions raised include: Does the media's portrayal of soldiers with mental illnesses present the public with an accurate picture? How does the representation of the behavioral health of soldiers affect behavioral health operations?

This appendix explores the possible operational impact of negative portrayals of soldiers with mental illnesses, using examples from Operation Iraqi Freedom (OIF) 05-07, through discussions of sensitive behavioral health issues such as suicide, portrayals of the combat environment to the public via documentaries such as *Baghdad ER*, and controversial events such as the killings in Haditha. In some cases media reporting can magnify the stigma experienced by soldiers with behavioral health problems, in addition to affecting the practices of military behavioral health. In other cases, the media can shed light on problems that need to be, and indeed are, addressed by military behavioral healthcare providers and policy makers.

BASICS OF INTERATING WITH THE MEDIA

Members of the media often approach military behavioral healthcare providers. If approached by a journalist, the first rule for the provider is to contact the public affairs office (PAO). PAO staff will handle negotiations with the media, and decide if it is an appropriate interaction. If an interview is approved, the interviewee should be prepared for surprise questions and always remember that quotations can be taken out of context. If giving a lecture, the speaker should keep in mind that media are often in the audience. Again, PAO staff should provide guidance for any public speaking or media interactions by military practitioners.

ISSUES AND CONCERNS WITH BEHAVIORAL HEALTH REPORTING ON IRAQ

During OIF 05-07, the war in Iraq entered its fourth year. Like all wars, the Iraq War is an extremely complex set of ever-changing dynamics. The battlefield has evolved considerably since US forces first invaded Iraq in 2003, changing from largely combat operations during the first months into civil-military endeavors since then. During this time the enemy had also evolved from organized Iraqi forces into varying militias, including some foreign fighters. Over 1,100 tribes live in the country; tribal territories often extend beyond Iraq's national boundaries. Other nation states also put external pressure on Iraq. Various religious and ethnic groups compete for scarce resources in the Bedouin cultural tradition. Privateers and black-marketers make a living in chaotic social and economic circumstances. Iraqi politicians maintain different views about the best way to govern. Despite this complex and evolving environment, media reports have sometimes given a simplified impression that the ongoing conflict results from sectarian violence between the Sunni, Shia, and Kurdish groups.

Combat stress or behavioral health assets were positioned throughout Iraq to help soldiers negotiate their way through these complex operational and emotional terrains. During OIF 05-07, the ongoing war in Iraq affected behavioral healthcare in two important ways. First, enough time had elapsed by then for military leaders to be aware of outcomes and problems that had arisen from OIF I (the first rotation) and OIF II (the second rotation). Consequently, new policies involving the behavioral health community were initiated (ie, suicide prevention, use of psychiatric medications; see Chapter 25, Suicide Prevention, and Chapter 10, Psychiatric Medications in Military Operations, respectively, for further discussion of these topics). Secondly, the length of the conflict and the number of casualties had generated increasing media interest in the war and in behavioral health services available to soldiers. Although it is impossible to determine to what extent the media influenced the day-to-day operations of behavioral health providers, the increased scrutiny did concern military leadership. This translated into greater cognizance of behavioral health activities.

The media has covered wars since the advent of print journalism. With the introduction of motion pictures, war coverage reached larger audiences throughout World War II. During this period, as well as during the Korean War, most of the video reporting of the war was seen in movie theaters. It was not until Vietnam that images of war were televised into the homes of the US populace. This footage, however, was generally edited at a network before it was aired

because the media lacked the capability of a live feed from the battlefield. Beginning with the Persian Gulf War (1990–1991), however, journalists were able to send live feeds from their embedded positions directly to television broadcasts. Commanders and politicians had virtually no time to review what might be broadcast, and in many cases heard of issues raised by the media only after they had been aired.

The following three issues—suicide, *Baghdad ER*, and Haditha—all of which involved situations during OIF 05-07, will be examined as they were reported by the media and acted upon by the military. Neither the nature of recent advances in media technology nor the media's effect on public opinion has been fully measured. However, it is not difficult to imagine that media coverage of behavioral health could have operational impacts and affect the behavior of soldiers. Mention Abu Ghraib or Haditha and one will elicit a wide range of reactions, from well informed to hearsay, from those responding. It is then that one can sense the true power and influence the media can have. The positive impact of this phenomenon is that the military often gains the attention and the political support it needs to address important psychological health needs of soldiers, for example, suicides in the Army.

Suicide Rates in the Army

Various media sources began reporting in 2003 that Army suicide rates were on the rise and that those soldiers deployed to Iraq and Kuwait experienced the greatest increase.[1] Although Army suicide statistics remained lower than for comparable age groups in the civilian population, the Army surgeon general, Lieutenant General James Peake, said that "any suicide is something we worry about and want to stop."[2] Despite the trend data being consistent with the civilian sector, recommendations were immediately implemented, including augmenting the Army's suicide prevention program and making behavioral healthcare more accessible to soldiers in combat and other high-stress environments. However, media reports, such as the articles on suicide, may alter mission focus and influence military behavioral health resources by diverting limited assets to respond to the reporting.

The Army's first mental health survey ever conducted in a combat zone took place in 2003 (see Chapter 5, Walter Reed Army Institute of Research Contributions During Operations Iraqi Freedom and Enduring Freedom, in this volume, for a more detailed discussion of the survey process). At the request of the commanding general, Combined Joint Task Force-7 of the US Central Command established and dispatched the first Mental Health Advisory Team (MHAT) to survey and provide recommendations on OIF-related behavioral health services. A team of 12 military and civilian psychiatrists, psychologists, social workers, and combat-stress experts surveyed 756 soldiers in Iraq between late August and early October 2003. They also surveyed behavioral health and medical care providers, unit leaders, and unit ministry staffs. The survey was conducted when conditions were at a low point: at the end of a very hot summer, before much of the infrastructure that created more comfortable living conditions had been put in place, and before most soldiers knew when they would redeploy to their home stations. The team leader of this first MHAT, Colonel Virgil Patterson, said one in four soldiers surveyed reported moderate or severe emotional, alcohol, or family problems. More than half reported low or very low morale.

After media reports on suicide began appearing, military behavioral health experts found themselves adding one additional task to their already significant duties: to maintain current and accurate data on suicide in theater and remain prepared to respond to media reports. For example, in 2003 the *Baltimore Sun* ran an article with the title "Army's Suicide Rate Has Outside Experts Alarmed," and the follow-on subtitle of "Most died serving in Iraq after major combat phase."[3] Similar reports were carried by most of the major news networks and papers. Later articles used language similar to that used by the *Baltimore Sun* in 2003. For example, the *Hartford Current* noted in 2007 that the "Army continues to struggle with suicides," and the "2006 Rate Of Self-Inflicted Deaths In Iraq Could Exceed Record Set In 2005."[4] Since OIF 05-07, an upward trend in suicide rates in active duty military has occurred, as discussed further in Chapter 25, Suicide Prevention, in this volume.

Baghdad ER

The 2006 HBO (Home Box Office) documentary *Baghdad ER* was a graphic and emotional account of the realities of war through the emergency room experiences of a combat support hospital. At the very outset of *Baghdad ER*, the producers pointed out that 90% of soldiers wounded in Iraq survive—the highest survival rate in American military history. (During OIF 05-07, survival rates exceeded 96%.[5])

Visual documentaries can serve as powerful reminders or "triggers" for soldiers who have been exposed to the sights, sounds, and smells of combat injuries; *Baghdad ER* was such a harsh reminder of the brutal realities of war. Military officials were allowed to preview the documentary and proactively prepare for its impact. The Army surgeon general at the time,

Lieutenant General Kevin Kiley, recommended that Army medicine plan for the effect that *Baghdad ER* might have on those who saw it. Said Kiley, "This film will have a strong impact on viewers and may cause anxiety for some soldiers and family members."[6] He noted that, "some may have strong reactions to the medical [surgical] procedures such as the amputation of a limb."[6] Kiley said military medical treatment facilities should be ready to assist troops and family members who might be upset after watching the film. He suggested that behavioral health facilities should extend their treatment hours and reach out to the troops proactively.[6] Kiley recognized that families and soldiers with ongoing psychological difficulties might have additional behavioral healthcare needs after the program aired. There were no known negative effects from viewing the program, although this was not systematically studied. From conversations with viewers, one of the authors (ECR) reported positive response to the program.

Haditha

Additional media interest in the military in Iraq came in the wake of the killing of 23 Iraqis on November 19, 2005, in Haditha, a city in the western Iraq province of Al Anbar. It was alleged that the killings were retribution for the attack on a convoy of US Marines with an improvised explosive device that killed Lance Corporal Miguel Terrazas.[7] A Marine Corps communiqué initially reported that 15 civilians were killed by the bomb's blast and 8 insurgents were subsequently killed when the Marines returned fire against those attacking the convoy. However, evidence provided by the media contradicted the Marines' account.[7] According to these media reports, at least 15, and allegedly all, of those killed were noncombatant civilians and were killed by the Marines.

Discussing the events in Haditha, psychiatrist Robert Jay Lifton explains that, "atrocity is a group activity."[8] Therefore, he wrote, "[t]o attribute the likely massacre at Haditha to 'a few bad apples' or to 'individual failures' is poor psychology and self-serving moralism."[8] Lifton says that the Haditha incident can be understood as what he calls "an atrocity-producing situation"—which he defines as

> one so structured, psychologically and militarily, that ordinary people, men or women no better or worse than you or I, can commit atrocities….Recognizing that atrocity is a group activity, one must ask how individual soldiers can so readily join in. I believe they undergo a type of dissociation that I call doubling—the formation of a second self. The individual psyche can adapt to an atrocity-producing environment by means of a sub-self that behaves as if it is autonomous and thereby joins in activities that would otherwise seem repugnant.[8]

In environments where sanctioned brutality becomes the norm, homicidal ideation and homicidal impulses, dormant in most individuals, are likely to be expressed.[9] The violent energy of the group becomes such that an individual soldier who questions it could by turned against by his or her peers. (For example, a Vietnam veteran who had been at My Lai told this author [JY] that he had refused to fire and pointedly lowered the barrel of his gun to the ground.) To resist intense group pressure requires a combination of conscience and moral courage, the very qualities that the military seeks to instill in soldiers as "core values."

Previously, Lifton explained his concept of atrocity-producing situations during a lecture about the possible torture of prisoners at Abu Ghraib.[8] In such situations, Lifton explained, although individuals are responsible for their own actions, when attempting to assign blame for atrocities it is perhaps more instructive to examine the conditions and examples set by higher commanders. When the rules of engagement do not appear to apply, or when ambiguities exist about what means may be used to achieve a "worthy" end, soldiers are less likely to adhere to the values that the military has sought to instill within them. Likewise, stress results from not knowing who the enemy is, not feeling safe, and witnessing evil. Cumulatively, these situations can contribute to behaviors that at times might exceed the rules of engagement. Additionally, the rules are sometimes difficult for a soldier to apply in the heat of battle or under circumstances outside normal soldier experiences or training. This explanation does not purport to dismiss the notion of accountability; however, it speaks to the process of "pathologizing" a new generation of soldiers.

Politics, social control, and mental health have long been tied together. For instance, diagnostic terms can reflect the bias of people and the times, such as "hysteria"—a term inherently biased against women. "Mental health" has been used both to limit civil rights and to advocate for civil rights. The former was discussed in the writings of the psychiatrist Thomas Szasz,[10] who suggested in 1961 that "mental illness" and the threat of being institutionalized were the means by which societies controlled those who strayed from the common morality. He advocated for the rights of those who had been institutionalized, setting in motion a movement that resulted in the release of many previously confined patients.[10]

SUMMARY

Behavioral healthcare in the military differs from the civilian practice in one distinct way: military behavioral health providers are tasked to conserve the fighting strength of the military. Thus, although they treat individuals, their focus is on the overall institution. Military providers accomplish their mission by caring for both US military personnel and their families. These providers, however, can be distracted by the situations that inevitably arise when complex mental health issues are reported in a simplified manner. The media can bring attention to areas indeed needing corrective action; however, the media can also sensationalize stories, as evidenced by titles like "Potent Mixture: Zoloft & a Rifle."[11]

The accurate presentation of behavioral health data is essential to combat and operational stress policy and doctrine; however, when data are misunderstood or reported out of context, they can undermine popular support for soldiers and potentially impact soldiers' mental health. Possible areas of operational consequences due to media coverage include changing policies on evacuation of behavioral health casualties, limiting use of psychotropic medication in theater, and lessening the trust in clinician "instincts." This operational impact has been termed the "CNN [Cable News Network] effect" and is seen as a double-edged sword—a "strategic enabler" and a potential operational risk.[12]

It is difficult to quantify the operational impact or strategic effect the media can have on behavioral health planning and execution. However, it is clear that the media are powerful forces shaping the environment in which behavioral health practitioners can work. Therefore, clinicians must be proactive as scientist-practitioners to demonstrate the efficacy of their practices, to plan effective battlefield interventions and operations for combat and operational stress control, and to assist with screening and surveillance of the service members within the scope of their responsibility. The media can also play a crucial role in drawing needed attention to situations in the military affecting soldiers in both garrison and operational settings. This unique convergence of two professional communities can contribute to conserving the fighting strength, which is, of course, the mission of all members of the military medical community.

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